Senate Bill No. 90

Passed the Senate April 7, 2011

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Secretary of the Senate

Passed the Assembly April 7, 2011

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Chief Clerk of the Assembly

This bill was received by the Governor this _____ day of _____, 2011, at _____ o'clock ___M.

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Private Secretary of the Governor

CHAPTER _____

An act to amend Section 130060 of the Health and Safety Code, and to amend Sections 14105.281, 14166.115, and 14167.10 of, to amend and repeal Section 14166.245 of, and to add and repeal Article 5.226 (commencing with Section 14168.1) and Article 5.227 (commencing with Section 14168.31) of Chapter 7 of Part 3 of Division 9 of, the Welfare and Institutions Code, relating to health, making an appropriation therefor, and declaring the urgency thereof, to take effect immediately.

LEGISLATIVE COUNSEL'S DIGEST

SB 90, Steinberg. Health: hospitals: Medi-Cal.

(1) Existing law establishes the Medi-Cal program, administered by the State Department of Health Care Services, under which basic health care services are provided to qualified low-income persons. The Medi-Cal program is, in part, governed and funded by federal Medicaid provisions.

Existing law authorizes the Director of Health Care Services to limit the rates of payment for health care services provided under the Medi-Cal program. Existing law requires, subject to federal approval, the department to freeze rates applicable to inpatient hospital services, as specified, and authorizes the department to modify the rate freeze in order to comply with federal Medicaid requirements.

This bill would provide that the rate freeze pursuant to these provisions shall become inoperative, and that any rate that was frozen pursuant to those provisions shall be restored retroactively to the rate that would have been in effect absent those provisions, on the effective date of this bill.

(2) Existing law requires the department to seek a demonstration project or federal waiver of Medicaid law to implement specified objectives, which may include better care coordination for seniors, persons with disabilities, and children with special health care needs. Existing law provides that to the extent the provisions under the Medi-Cal Hospital/Uninsured Care Demonstration Project Act do not conflict with the provisions of, or the Special Terms and Conditions of, this demonstration project, the provisions of the

Medi-Cal Hospital/Uninsured Care Demonstration Project Act shall apply. Existing law requires the department to reduce disproportionate share hospital replacement payments to private hospitals by 10%, as specified.

This bill would provide that, in addition to the 10% reduction, disproportionate share hospital replacement payments to private hospitals shall be reduced in the 2010–11 fiscal year by an additional $30 million in General Fund moneys and by the corresponding federal financial participation. To the extent permitted by federal law, the bill would provide that the additional room under the federal Upper Payment Limit created by this reduction shall be used to increase the above-described supplemental payments. This bill would also provide that, in addition to the 10% reduction, disproportionate share hospital replacement payments to private hospitals shall be reduced in the 2011–12 fiscal year by an additional $75 million in General Fund moneys and by the corresponding federal financial participation. To the extent permitted by federal law, the bill would provide that the additional room under the federal Upper Payment Limit created by this reduction shall be used to increase supplemental payments under subsequent legislation extending or creating a new supplemental hospital payment program supported by a fee.

(3) Existing law, until January 1, 2013, reduces interim payments by 10% for inpatient hospital services provided on and after July 1, 2008, at all hospitals that receive Medi-Cal reimbursement from the department and that are not under selective contracts with the department.

This bill would, commencing on the effective date of this bill, provide that these provisions shall no longer be applicable to fee-for-service hospital rates but shall continue to be applicable as specified.

(4) Existing law, subject to federal approval, imposes a quality assurance fee, as specified, on certain general acute care hospitals through and including December 31, 2010. Existing law creates the Hospital Quality Assurance Revenue Fund in the State Treasury and requires that the money collected from the quality assurance fee be deposited into the fund.

Existing law, subject to federal approval, requires the department to make supplemental payments for certain services, as specified, to private hospitals, nondesignated public hospitals, and designated

public hospitals, as defined, for subject fiscal years, as defined. Existing law also requires the department to increase capitation payments to Medi-Cal managed care plans, increase payments to mental health plans, and make direct grants to designated public hospitals, as specified. Existing law provides that the moneys in the Hospital Quality Assurance Revenue Fund shall, upon appropriation by the Legislature, be available only for certain purposes, including providing the supplemental payments to hospitals, direct grants to designated public hospitals, increased capitation payments to Medi-Cal managed care plans, and increased payments to mental health plans. Existing law also establishes the continuously appropriated Distressed Hospital Fund, which consists of moneys transferred to the fund or appropriated by the Legislature and used as the nonfederal share of payments to distressed hospitals, as defined.

This bill would, subject to federal approval, commencing January 1, 2011, through and including June 30, 2011, impose a quality assurance fee, as specified, on certain general acute care hospitals. This bill would require that the moneys collected from the quality assurance fee be deposited into the Hospital Quality Assurance Revenue Fund. The bill would, subject to federal approval, provide that the moneys in the Hospital Quality Assurance Revenue Fund shall, upon appropriation by the Legislature, be available only for certain purposes, including providing supplemental payments for certain services to private hospitals, increased capitation payments to Medi-Cal managed care plans, and increased payments to mental health plans. The bill would provide that if quality assurance fee payments are remitted to the department after the date determined by the department to be the final date for calculating the final supplemental payments, the fee payments shall be retained in the fund for purposes of funding supplemental payments supported by a hospital quality assurance fee program under subsequent legislation, but provides that if supplemental payments are not implemented under subsequent legislation, then those quality assurance fee payments shall be deposited into the Distressed Hospital Fund. The bill would also provide that if amounts of the quality assurance fees are collected in excess of the funds required to make the payments above and federal rules prohibit the department from refunding the fee payments to the general acute care hospitals, the excess funds shall be deposited into the

Distressed Hospital Fund. By increasing the amount of money that may be deposited into the Distressed Hospital Fund, this bill would make an appropriation. The bill would also require that the department design and implement, in consultation with the designated and nondesignated public hospitals, an intergovernmental transfer program relating to Medi-Cal managed care services provided by designated and nondesignated public hospitals in order to increase capitation payments for the purpose of increasing their reimbursement.

(5) Existing law requires, after January 1, 2008, that any general acute care hospital building that is determined to be a potential risk of collapse or pose significant loss of life may only be used for nonacute care hospital purposes, unless granted an extension as prescribed.

This bill would authorize the Office of Statewide Health Planning and Development to grant a hospital an additional extension of up to 7 years for a hospital building that it owns or operates if the hospital meets specified milestones. This bill would require a hospital that applies for this extension to pay the office an additional fee, to be determined by the office, sufficient to cover the additional reasonable costs incurred by the office for maintaining the additional reporting requirements established by these provisions. This bill would provide that this provision shall become operative on the date the department receives all necessary federal approvals for a 2011–12 fiscal year hospital quality assurance fee program that includes $320 million in fee revenue to pay for health care coverage for children, as specified.

(6) This bill would become operative only if AB 113 of the 2011–12 Regular Session of the Legislature is enacted.

(7) This bill would declare that it is to take effect immediately as an urgency statute.

Appropriation: yes.

The people of the State of California do enact as follows:

SECTION 1. Section 130060 of the Health and Safety Code is amended to read:

130060. (a) (1) After January 1, 2008, any general acute care hospital building that is determined to be a potential risk of collapse or pose significant loss of life shall only be used for nonacute care

hospital purposes. A delay in this deadline may be granted by the office upon a demonstration by the owner that compliance will result in a loss of health care capacity that may not be provided by other general acute care hospitals within a reasonable proximity. In its request for an extension of the deadline, a hospital shall state why the hospital is unable to comply with the January 1, 2008, deadline requirement.

(2) Prior to granting an extension of the January 1, 2008, deadline pursuant to this section, the office shall do all of the following:

(A) Provide public notice of a hospital's request for an extension of the deadline. The notice, at a minimum, shall be posted on the office's Internet Web site, and shall include the facility's name and identification number, the status of the request, and the beginning and ending dates of the comment period, and shall advise the public of the opportunity to submit public comments pursuant to subparagraph (C). The office shall also provide notice of all requests for the deadline extension directly to interested parties upon request of the interested parties.

(B) Provide copies of extension requests to interested parties within 10 working days to allow interested parties to review and provide comment within the 45-day comment period. The copies shall include those records that are available to the public pursuant to the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code).

(C) Allow the public to submit written comments on the extension proposal for a period of not less than 45 days from the date of the public notice.

(b) (1) It is the intent of the Legislature, in enacting this subdivision, to facilitate the process of having more hospital buildings in substantial compliance with this chapter and to take nonconforming general acute care hospital inpatient buildings out of service more quickly.

(2) The functional contiguous grouping of hospital buildings of a general acute care hospital, each of which provides, as the primary source, one or more of the hospital's eight basic services as specified in subdivision (a) of Section 1250, may receive a five-year extension of the January 1, 2008, deadline specified in subdivision (a) of this section pursuant to this subdivision for both

structural and nonstructural requirements. A functional contiguous grouping refers to buildings containing one or more basic hospital services that are either attached or connected in a way that is acceptable to the State Department of Health Care Services. These buildings may be either on the existing site or a new site.

(3) To receive the five-year extension, a single building containing all of the basic services or at least one building within the contiguous grouping of hospital buildings shall have obtained a building permit prior to 1973 and this building shall be evaluated and classified as a nonconforming, Structural Performance Category-1 (SPC-1) building. The classification shall be submitted to and accepted by the Office of Statewide Health Planning and Development. The identified hospital building shall be exempt from the requirement in subdivision (a) until January 1, 2013, if the hospital agrees that the basic service or services that were provided in that building shall be provided, on or before January 1, 2013, as follows:

(A) Moved into an existing conforming Structural Performance Category-3 (SPC-3), Structural Performance Category-4 (SPC-4), or Structural Performance Category-5 (SPC-5) and Non-Structural Performance Category-4 (NPC-4) or Non-Structural Performance Category-5 (NPC-5) building.

(B) Relocated to a newly built compliant SPC-5 and NPC-4 or NPC-5 building.

(C) Continued in the building if the building is retrofitted to a SPC-5 and NPC-4 or NPC-5 building.

(4) A five-year extension is also provided to a post-1973 building if the hospital owner informs the Office of Statewide Health Planning and Development that the building is classified as SPC-1, SPC-3, or SPC-4 and will be closed to general acute care inpatient service use by January 1, 2013. The basic services in the building shall be relocated into a SPC-5 and NPC-4 or NPC-5 building by January 1, 2013.

(5) SPC-1 buildings, other than the building identified in paragraph (3) or (4), in the contiguous grouping of hospital buildings shall also be exempt from the requirement in subdivision (a) until January 1, 2013. However, on or before January 1, 2013, at a minimum, each of these buildings shall be retrofitted to a SPC-2 and NPC-3 building, or no longer be used for general acute care hospital inpatient services.

(c) On or before March 1, 2001, the office shall establish a schedule of interim work progress deadlines that hospitals shall be required to meet to be eligible for the extension specified in subdivision (b). To receive this extension, the hospital building or buildings shall meet the year 2002 nonstructural requirements.

(d) A hospital building that is eligible for an extension pursuant to this section shall meet the January 1, 2030, nonstructural and structural deadline requirements if the building is to be used for general acute care inpatient services after January 1, 2030.

(e) Upon compliance with subdivision (b), the hospital shall be issued a written notice of compliance by the office. The office shall send a written notice of violation to hospital owners that fail to comply with this section. The office shall make copies of these notices available on its Internet Web site.

(f) (1) A hospital that has received an extension of the January 1, 2008, deadline pursuant to subdivision (a) or (b) may request an additional extension of up to two years for a hospital building that it owns or operates and that meets the criteria specified in paragraph (2), (3), or (5).

(2) The office may grant the additional extension if the hospital building subject to the extension meets all of the following criteria:

(A) The hospital building is under construction at the time of the request for extension under this subdivision and the purpose of the construction is to meet the requirements of subdivision (a) to allow the use of the building as a general acute care hospital building after the extension deadline granted by the office pursuant to subdivision (a) or (b).

(B) The hospital building plans were submitted to the office and were deemed ready for review by the office at least four years prior to the applicable deadline for the building. The hospital shall indicate, upon submission of its plans, the SPC-1 building or buildings that will be retrofitted or replaced to meet the requirements of this section as a result of the project.

(C) The hospital received a building permit for the construction described in subparagraph (A) at least two years prior to the applicable deadline for the building.

(D) The hospital submitted a construction timeline at least two years prior to the applicable deadline for the building demonstrating the hospital’s intent to meet the applicable deadline. The timeline shall include all of the following:

(i) The projected construction start date.

(ii) The projected construction completion date.

(iii) Identification of the contractor.

(E) The hospital is making reasonable progress toward meeting the timeline set forth in subparagraph (D), but factors beyond the hospital's control make it impossible for the hospital to meet the deadline.

(3) The office may grant the additional extension if the hospital building subject to the extension meets all of the following criteria:

(A) The hospital building is owned by a health care district that has, as owner, received the extension of the January 1, 2008, deadline, but where the hospital is operated by an unaffiliated third-party lessee pursuant to a facility lease that extends at least through December 31, 2009. The district shall file a declaration with the office with a request for an extension stating that, as of the date of the filing, the district has lacked, and continues to lack, unrestricted access to the subject hospital building for seismic planning purposes during the term of the lease, and that the district is under contract with the county to maintain hospital services when the hospital comes under district control. The office shall not grant the extension if an unaffiliated third-party lessee will operate the hospital beyond December 31, 2010.

(B) The hospital building plans were submitted to the office and were deemed ready for review by the office at least four years prior to the applicable deadline for the building. The hospital shall indicate, upon submission of its plans, the SPC-1 building or buildings that will be retrofitted or replaced to meet the requirements of this section as a result of the project.

(C) The hospital received a building permit for the construction described in subparagraph (B) by December 31, 2011.

(D) The hospital submitted, by December 31, 2011, a construction timeline for the building demonstrating the hospital's intent and ability to meet the deadline of December 31, 2014. The timeline shall include all of the following:

(i) The projected construction start date.

(ii) The projected construction completion date.

(iii) Identification of the contractor.

(E) The hospital building is under construction at the time of the request for the extension, the purpose of the construction is to meet the requirements of subdivision (a) to allow the use of the

building as a general acute care hospital building after the extension deadline granted by the office pursuant to subdivision (a) or (b), and the hospital is making reasonable progress toward meeting the timeline set forth in subparagraph (D).

(F) The hospital granted an extension pursuant to this paragraph shall submit an additional status report to the office, equivalent to that required by subdivision (c) of Section 130061, no later than June 30, 2013.

(4) An extension granted pursuant to paragraph (3) shall be applicable only to the health care district applicant and its affiliated hospital while the hospital is operated by the district or an entity under the control of the district.

(5) The office may grant the additional extension if the hospital building subject to the extension meets all of the following criteria:

(A) The hospital owner submitted to the office, prior to June 30, 2009, a request for review using current computer modeling utilized by the office and based upon software developed by the Federal Emergency Management Agency, referred to as Hazards US, and the building was deemed SPC-1 after that review.

(B) The hospital building plans for the building are submitted to the office and deemed ready for review by the office prior to July 1, 2010. The hospital shall indicate, upon submission of its plans, the SPC-1 building or buildings that shall be retrofitted or replaced to meet the requirements of this section as a result of the project.

(C) The hospital receives a building permit from the office for the construction described in subparagraph (B) prior to January 1, 2012.

(D) The hospital submits, prior to January 1, 2012, a construction timeline for the building demonstrating the hospital's intent and ability to meet the applicable deadline. The timeline shall include all of the following:

(i) The projected construction start date.

(ii) The projected construction completion date.

(iii) Identification of the contractor.

(E) The hospital building is under construction at the time of the request for the extension, the purpose of the construction is to meet the requirements of subdivision (a) to allow the use of the building as a general acute care hospital building after the extension deadline granted by the office pursuant to subdivision (a) or (b),

and the hospital is making reasonable progress toward meeting the timeline set forth in subparagraph (D).

(F) The hospital owner completes construction such that the hospital meets all criteria to enable the office to issue a certificate of occupancy by the applicable deadline for the building.

(6) A hospital denied an extension pursuant to this subdivision may appeal the denial to the Hospital Building Safety Board.

(7) The office may revoke an extension granted pursuant to this subdivision for any hospital building where the work of construction is abandoned or suspended for a period of at least one year, unless the hospital demonstrates in a public document that the abandonment or suspension was caused by factors beyond its control.

(g) (1) Notwithstanding subdivisions (a), (b), (c), and (f), and Sections 130061.5 and 130064, a hospital that has received an extension of the January 1, 2008, deadline pursuant to subdivision (a) or (b) also may request an additional extension of up to seven years for a hospital building that it owns or operates. The office may grant the extension subject to the hospital meeting the milestones set forth in paragraph (2).

(2) The hospital building subject to the extension shall meet all of the following milestones, unless the hospital building is reclassified as SPC-2 or higher as a result of its Hazards US score:

(A) The hospital owner submits to the office, no later than March 31, 2012, a letter of intent stating whether it intends to rebuild, replace, or retrofit the building, or remove all general acute care beds and services from the building, and the amount of time necessary to complete the construction.

(B) The hospital owner submits to the office, no later than March 31, 2012, a schedule detailing why the requested extension is necessary, and specifically how the hospital intends to meet the requested deadline.

(C) The hospital owner submits to the office, no later than September 30, 2012, an application ready for review seeking structural reassessment of each of its SPC-1 buildings using current computer modeling based upon software developed by FEMA, referred to as Hazards US.

(D) The hospital owner submits to the office, no later than January 1, 2015, plans ready for review consistent with the letter

of intent submitted pursuant to subparagraph (A) and the schedule submitted pursuant to subparagraph (B).

(E) The hospital owner submits a financial report to the office at the time the plans are submitted pursuant to subparagraph (D). The report shall demonstrate the hospital owner's financial capacity to implement the construction plans submitted pursuant to subparagraph (D).

(F) The hospital owner receives a building permit consistent with the letter of intent submitted pursuant to subparagraph (A) and the schedule submitted pursuant to subparagraph (B), no later than July 1, 2018.

(3) To evaluate public safety and determine whether to grant an extension of the deadline, the office shall consider the structural integrity of the hospital's SPC-1 buildings based on its Hazards US scores, community access to essential hospital services, and the hospital owner's financial capacity to meet the deadline as determined by either a bond rating of BBB or below or the financial report on the hospital owner's financial capacity submitted pursuant to subparagraph (E) of paragraph (2). The criteria contained in this paragraph shall be considered by the office in its determination of the length of an extension or whether an extension should be granted.

(4) The extension or subsequent adjustments granted pursuant to this subdivision may not exceed the amount of time that is reasonably necessary to complete the construction specified in paragraph (2).

(5) If the circumstances underlying the request for extension submitted to the office pursuant to paragraph (2) change, the hospital owner shall notify the office as soon as practicable, but in no event later than six months after the hospital owner discovered the change of circumstances. The office may adjust the length of the extension granted pursuant to paragraphs (2) and (3) as necessary, but in no event longer than the period specified in paragraph (1).

(6) A hospital denied an extension pursuant to this subdivision may appeal the denial to the Hospital Building Safety Board.

(7) The office may revoke an extension granted pursuant to this subdivision for any hospital building when it is determined that any information submitted pursuant to this section was falsified, or if the hospital failed to meet a milestone set forth in paragraph

(2), or where the work of construction is abandoned or suspended for a period of at least six months, unless the hospital demonstrates in a publicly available document that the abandonment or suspension was caused by factors beyond its control.

(8) Regulatory submissions made by the office to the California Building Standards Commission to implement this section shall be deemed to be emergency regulations and shall be adopted as emergency regulations.

(9) The hospital owner that applies for an extension pursuant to this subdivision shall pay the office an additional fee, to be determined by the office, sufficient to cover the additional reasonable costs incurred by the office for maintaining the additional reporting requirements established under this section, including, but not limited to, the costs of reviewing and verifying the extension documentation submitted pursuant to this subdivision. This additional fee shall not include any cost for review of the plans or other duties related to receiving a building or occupancy permit.

(10) This subdivision shall become operative on the date that the State Department of Health Care Services receives all necessary federal approvals for a 2011–12 fiscal year hospital quality assurance fee program that includes three hundred twenty million dollars ($320,000,000) in fee revenue to pay for health care coverage for children, which is made available as a result of the legislative enactment of a 2011–12 fiscal year hospital quality assurance fee program.

SEC. 2. Section 14105.281 of the Welfare and Institutions Code is amended to read:

14105.281. (a) The Legislature finds and declares all of the following:

(1) That because the implementation of Section 14105.28 is expected to require several years and further rate changes may make the transition to an inpatient hospital reimbursement methodology based on diagnosis-related groups more difficult, and because of the need to take into account the amount of base payments when combined with supplemental payments made to inpatient hospitals, including payments provided as a result of the hospital fee set forth in Article 5.22 (commencing with Section 14167.31) and Article 5.225 (commencing with Section 14167.41), it is necessary to impose the rate freeze enacted in this section.

(2) (A) Upon implementation of Article 5.21 (commencing with Section 14167.1) and Article 5.22 (commencing with Section 14167.31), as added by Assembly Bill 1383 of the 2009–10 Regular Session, supplemental payments shall be made to hospitals that have contracts negotiated pursuant to the Selective Provider Contracting Program, provided that rates under these contracts are not reduced below the contract rates in effect on the effective date of Article 5.21 (commencing with Section 14167.1), as added by Assembly Bill 1383 of the 2009–10 Regular Session.

(B) Assembly Bill 1383 of the 2009–10 Regular Session was signed into law on October 11, 2009, and the effective date of Article 5.21 (commencing with Section 14167.1) was January 1, 2010. Therefore, in consideration of the notice provided by Assembly Bill 1383 of the 2009–10 Regular Session, and in further consideration that the negotiated contract rates in effect on January 1, 2010, or the rates in effect on July 1, 2010, to the extent those rates are lower than the rates in effect on January 1, 2010, as provided in paragraph (1) of subdivision (c), are sufficient to conform with the standards set forth in Section 1396a(a)(30)(A) of Title 42 of the United States Code, as well as the existence of supplemental payments to be made under Article 5.21 (commencing with Section 14167.1), the Legislature exercises its discretion, in consultation with the department, to freeze rates at the levels in effect for these hospitals on January 1, 2010, or the rates in effect on July 1, 2010, to the extent that those rates are lower than the rates in effect on January 1, 2010, as provided in paragraph (1) of subdivision (c).

(3) The freeze shall remain in effect during the period of time supplemental payments are made under Article 5.21 (commencing with Section 14167.1), and thereafter, to the extent that the rates, alone or in combination with any available supplemental payments, are consistent with federal law as provided in this section.

(b) Notwithstanding any other provision of law, in order to develop and implement changes in the methodology for payments for hospital inpatient services, the director shall freeze rates applicable to inpatient hospital services, as specified in this section.

(c) (1) Reimbursement rates for inpatient hospital services for all hospitals, except designated public hospitals, as defined in subdivision (d) of Section 14166.1, that receive Medi-Cal reimbursement from the State Department of Health Care Services,

both under contract with the Selective Provider Contracting Program as well as noncontract hospitals, shall be frozen to the lesser of the amount paid on January 1, 2010, or the amount paid on July 1, 2010. The rate freeze shall be in effect for reimbursements for inpatient hospital services provided to Medi-Cal beneficiaries beginning on July 1, 2010, through and including the date on which the Medicaid Management Information System converts to claim processing based on the new reimbursement methodology developed pursuant to Section 14105.28 and described in paragraph (1) of subdivision (b) of that section.

(2) In the event a contract hospital terminates its contract and becomes a noncontract hospital, the hospital shall receive the same rate or rates as provided in paragraph (1) as a contract hospital for inpatient hospital services provided to Medi-Cal eligible individuals while the rate freeze specified in paragraph (1) remains in effect.

(3) This section nullifies any agreement between the state and a hospital for rate adjustments that would be inconsistent with this section. Other provisions of any of those agreements shall be unchanged by this section.

(4) In the event a noncontract hospital elects to become a contract hospital after July 1, 2010, at a negotiated rate or negotiated rates less than the freeze amount provided in paragraph (1), the hospital shall receive the contract rate or rates while the freeze remains in effect.

(d) For purposes of this section, the reimbursement for inpatient hospital services includes the amounts paid for all categories of inpatient services allowable by Medi-Cal and shall not include any supplemental payments. The reimbursement includes the amounts paid for routine services together with all related ancillary services.

(e) Within 90 days of the date this section becomes effective, the department shall develop and provide to all hospitals the methodology that will be utilized to implement the rate freeze required by this section for noncontract hospitals.

(f) (1) For dates of service on and after July 1, 2010, the department shall reconcile the payments, as limited by subdivision (c), to the amounts that the hospitals, that are subject to the new methodology set forth in Section 14105.28, would have received if the new methodology had been in effect. The department shall identify the data that will be used in making the reconciliations.

(2) The department shall implement the reconciliation process on the date that the payment methodology based on diagnosis-related groups has been made final, but no later than June 30, 2012. The director shall execute a declaration stating the date on which the new payment methodology has become final.

(3) In the process of reconciliation, no payment, with respect to dates of service prior to the effective date of the act that added this section, shall be reduced below the amount paid pursuant to subdivision (c).

(4) Rates paid to hospitals, or for specified services, that are not subject to the methodology in paragraph (1) of subdivision (b) of Section 14105.28, shall be increased subject to the annual Budget Act.

(g) Notwithstanding subdivision (c) or any other provision of this section, for the 2011–12 fiscal year and each fiscal year thereafter, or portion thereof, in which subdivision (c) remains in effect, the department shall, subject to an appropriation in the annual Budget Act applicable to the particular fiscal year, apply an increase in reimbursement rates for all hospital services that result from the freeze imposed pursuant to subdivision (c).

(h) Notwithstanding the rulemaking provisions of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may take the actions specified in this section by means of provider bulletins or notices, policy letters, or other similar instructions, without taking regulatory action.

(i) (1) The rates provided for in this section shall be implemented only if the director determines that the rates, as established by this section, will comply with applicable federal Medicaid requirements and that federal financial participation will be available.

(2) In assessing whether federal financial participation is available, the director shall determine whether the rates comply with applicable federal Medicaid requirements, including those set forth in Section 1396a(a)(30)(A) of Title 42 of the United States Code.

(3) To the extent that the director determines that the rates do not comply with the federal Medicaid requirements, the director retains the discretion not to implement that rate and may revise the rate as necessary to comply with federal Medicaid requirements.

(j) The director shall seek any necessary federal approval for the implementation of this section. To the extent that federal financial participation is not available with respect to any rate of reimbursement described by this section, the director retains the discretion not to implement that rate and may revise the rate as necessary to comply with the federal Medicaid requirements.

(k) Subdivisions (a) to (g), inclusive, shall become inoperative, and any rate that was frozen pursuant to this section shall be restored retroactively to the rate that would have been in effect absent this section, on the effective date of the act that added this subdivision. The department shall explore other avenues that do not involve a rate freeze for achieving the stability needed, including determining base payment rates, in order to transition to an inpatient hospital reimbursement methodology based on diagnosis-related groups.

SEC. 3. Section 14166.115 of the Welfare and Institutions Code is amended to read:

14166.115. (a) Due to the state budget deficit and in order to implement changes in the level of funding for health care services, the department shall reduce disproportionate share hospital replacement payments to private hospitals made pursuant to Section 14166.11 as specified in this section.

(b) (1) Disproportionate share hospital replacement payments to private hospitals pursuant to Section 14166.11 shall be reduced by 10 percent. The reductions shall be applied to all disproportionate share hospital replacement payments to private hospitals made for the 2009–10 fiscal year, including, but not limited to, interim payments, tentative adjusted monthly payments, data corrected payments, and the final adjusted payment.

(2) In addition to the reduction provided for in paragraph (1), disproportionate share hospital replacement payments to private hospitals pursuant to Section 14166.11 shall be reduced in the 2010–11 fiscal year by an additional thirty million dollars ($30,000,000) in General Fund moneys and by the corresponding federal financial participation. To the extent permitted by federal law, the additional room created by this paragraph under the federal upper payment limit shall be used to increase supplemental payments under Article 5.226 (commencing with Section 14168.1) and Article 5.227 (commencing with Section 14168.31).

(3) In addition to the reduction provided for in paragraph (1), disproportionate share hospital replacement payments to private hospitals pursuant to Section 14166.11 shall be reduced in the 2011–12 fiscal year by an additional seventy-five million dollars ($75,000,000) in General Fund moneys and by the corresponding federal financial participation. To the extent permitted by federal law, the additional room created by this paragraph under the federal upper payment limit shall be used to increase supplemental payments under subsequent legislation extending or creating a new supplemental hospital payment program supported by a fee.

(c) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement and administer this section by means of provider bulletins, or similar instructions, without taking further regulatory action.

(d) The reductions described in this section shall apply only to payments for services when the General Fund share of the payment is paid with funds appropriated to the department in the annual Budget Act.

(e) The department shall promptly seek any necessary federal approvals for the implementation of this section.

SEC. 4. Section 14166.245 of the Welfare and Institutions Code, as amended by Section 50 of Chapter 5 of the Fourth Extraordinary Session of the Statutes of 2009, is amended to read:

14166.245. (a) The Legislature finds and declares that the state faces a fiscal crisis that requires unprecedented measures to be taken to reduce General Fund expenditures to avoid reducing vital government services necessary for the protection of the health, safety, and welfare of the citizens of the State of California.

(b) (1) Notwithstanding any other provision of law, except as provided in Article 2.93 (commencing with Section 14091.3), for hospitals that receive Medi-Cal reimbursement from the State Department of Health Care Services and that are not under contract with the State Department of Health Care Services pursuant to Article 2.6 (commencing with Section 14081) of Chapter 7 of Part 3 of Division 9, the amounts paid as interim payments for inpatient hospital services provided on and after July 1, 2008, shall be reduced by 10 percent.

(2) (A) Beginning on October 1, 2008, amounts paid that are calculated pursuant to paragraph (1) shall not exceed the applicable

regional average per diem contract rate for tertiary hospitals and for all other hospitals established as specified in subparagraph (C), reduced by 5 percent, multiplied by the number of Medi-Cal covered inpatient days for which the interim payment is being made.

(B) This paragraph shall not apply to small and rural hospitals specified in Section 124840 of the Health and Safety Code, or to hospitals in open health facility planning areas that were open health facility planning areas on October 1, 2008, unless either of the following apply:

(i) The open health facility planning area at any time on or after July 1, 2005, was a closed health facility planning area as determined by the California Medical Assistance Commission.

(ii) The open health facility planning area has three or more hospitals with licensed general acute care beds. State-owned or operated hospitals shall not be included in determining whether this clause shall apply.

(C) (i) For purposes of this subdivision and subdivision (c), the average regional per diem contract rates shall be derived from unweighted average contract per diem rates that are publicly available on June 1 of each year, trended forward based on the trends in the California Medical Assistance Commission's Annual Report to the Legislature. For tertiary hospitals, and for all other hospitals, the regional average per diem contract rates shall be based on the geographic regions in the California Medical Assistance Commission's Annual Report to the Legislature. The applicable average regional per diem contract rates for tertiary hospitals and for all other hospitals shall be published by the department on or before October 1, 2008, and these rates shall be updated annually for each state fiscal year and shall become effective each July 1, thereafter. Supplemental payments shall not be included in this calculation.

(ii) For purposes of clause (i), both the federal and nonfederal share of the designated public hospital cost-based rates shall be included in the determination of the average contract rates by multiplying the hospital's interim rate, established pursuant to Section 14166.4 and that is in effect on June 1 of each year, by two.

(iii) For the purposes of this section, a tertiary hospital is a children's hospital specified in Section 10727, or a hospital that

has been designated as a Level I or Level II trauma center by the Emergency Medical Services Authority established pursuant to Section 1797.1 of the Health and Safety Code.

(D) For purposes of this section, the terms "open health facility planning area" and "closed health facility planning area" shall have the same meaning and be applied in the same manner as used by the California Medical Assistance Commission in the implementation of the hospital contracting program authorized in Article 2.6 (commencing with Section 14081).

(c) (1) Notwithstanding any other provision of law, for hospitals that receive Medi-Cal reimbursement from the State Department of Health Care Services and that are not under contract with the State Department of Health Care Services, pursuant to Article 2.6 (commencing with Section 14081), the reimbursement amount paid by the department for inpatient services provided to Medi-Cal recipients for dates of service on and after July 1, 2008, shall not exceed the amount determined pursuant to paragraph (3).

(2) For purposes of this subdivision, the reimbursement for inpatient services includes the amounts paid for all categories of inpatient services allowable by Medi-Cal. The reimbursement includes the amounts paid for routine services, together with all related ancillary services.

(3) When calculating a hospital's cost report settlement for a hospital's fiscal period that includes any dates of service on and after July 1, 2008, the settlement for dates of service on and after July 1, 2008, shall be limited to the lesser of the following:

(A) Ninety percent of the hospital's audited allowable cost per day for those services multiplied by the number of Medi-Cal covered inpatient days in the hospital's fiscal year on or after July 1, 2008.

(B) Beginning for dates of service on and after October 1, 2008, the applicable average regional per diem contract rate established as specified in subparagraph (A) of paragraph (2) of subdivision (b), reduced by 5 percent, multiplied by the number of Medi-Cal covered inpatient days in the hospital's fiscal year, or portion thereof. This subparagraph shall not apply to small and rural hospitals specified in Section 124840 of the Health and Safety Code, or to hospitals in open health facility planning areas that were open health facility planning areas on July 1, 2008, unless either of the following apply:

(i) The open health facility planning area at any time on or after July 1, 2005, was a closed health facility planning area as determined by the California Medical Assistance Commission.

(ii) The open health facility planning area has three or more hospitals with licensed general acute care beds. State-owned or operated hospitals shall not be included in determining whether this clause shall apply.

(d) Except as provided in Article 2.93 (commencing with Section 14091.3), hospitals that participate in the Selective Provider Contracting Program pursuant to Article 2.6 (commencing with Section 14081) and designated public hospitals under Section 14166.1, except Los Angeles County Martin Luther King, Jr./Charles R. Drew Medical Center and Tuolumne General Hospital, shall be exempt from the limitations required by this section.

(e) Notwithstanding the rulemaking provisions of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the director may implement and administer this section by means of provider bulletins, or other similar instructions, without taking regulatory action.

(f) The director shall promptly seek all necessary federal approvals in order to implement this section, including necessary amendments to the state plan.

(g) (1) Notwithstanding any other provision of this section, small and rural hospitals, as defined in Section 124840 of the Health and Safety Code, shall be exempt from the payment reductions set forth in this section for dates of service on and after November 1, 2008, through and including June 30, 2009. On and after July 1, 2009, small and rural hospitals as defined in this paragraph shall be subject to the reductions set forth in paragraph (1) of subdivision (b) and subparagraph (A) of paragraph (3) of subdivision (c), but shall be exempt from the provisions of subparagraph (A) of paragraph (2) of subdivision (b) and subparagraph (B) of paragraph (3) of subdivision (c).

(2) Notwithstanding any other provision of this section, hospitals that are certified by Medicare as Medical Critical Access Providers or as Rural Referral Centers shall be exempt from the payment reductions set forth in this section for dates of service on and after July 1, 2009.

(h) For hospitals that are subject to clauses (i) and (ii) of subparagraph (B) of paragraph (2) of subdivision (b) and that choose to contract pursuant to Article 2.6 (commencing with Section 14081), the California Medical Assistance Commission shall negotiate rates taking into account factors specified in Section 14083.

(i) In January 2010 and in January 2011, the department and the California Medical Assistance Commission shall submit a written report to the policy and fiscal committees of the Legislature on the implementation and impact of the changes made by this section, including, but not limited to, the impact of those changes on the number of hospitals that are contract and noncontract, patient access, and cost savings to the state.

(j) Commencing on the effective date of the act that added this subdivision, all of the following shall occur:

(1) Subdivisions (a) to (d), inclusive, and subdivisions (g) to (h), inclusive, shall no longer be applicable to fee-for-service hospital rates but shall continue to be applicable under subdivision (c) of Section 14091.3, in the same manner and to the same extent as if this section continued to be applicable to fee-for-service hospital rates.

(2) Medi-Cal reimbursement for inpatient hospital services for hospitals that receive Medi-Cal reimbursement from the department and that are not under contract with the department pursuant to Article 2.6 (commencing with Section 14081) for inpatient hospital services shall be determined in accordance with the applicable provisions in state law and the California Code of Regulations, and the applicable provisions of the California Medicaid State Plan that have been approved by the federal Centers for Medicare and Medicaid Services without application of subdivisions (a) to (d), inclusive, and subdivisions (g) to (h), inclusive.

(k) The reimbursement reductions and limits set forth in, or adopted pursuant to, Section 14105.192 do not apply to payments for inpatient hospital services furnished on a fee-for-service basis under Medi-Cal to hospitals that are not under contract with the department pursuant to Article 2.6 (commencing with Section 14081) for inpatient services provided to Medi-Cal beneficiaries.

(*l*) This section shall remain in effect only until January 1, 2013, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2013, deletes or extends that date.

SEC. 5. Section 14166.245 of the Welfare and Institutions Code, as added by Section 58 of Chapter 758 of the Statutes of 2008, is repealed.

SEC. 6. Section 14167.10 of the Welfare and Institutions Code is amended to read:

14167.10. (a) Each managed health care plan receiving increased capitation payments under Section 14167.6 shall expend the capitation rate increases in a manner consistent with actuarial certification, enrollment, and utilization on hospital services. Each managed health care plan shall expend increased capitation payments on hospital services within 30 days of receiving the increased capitation payments to the extent they are made for a subject month that is prior to the date on which the payments are received by the managed health care plan.

(b) For each subject fiscal year, the sum of all expenditures made by a managed health care plan for hospital services pursuant to this section shall equal, or approximately equal, all increased capitation payments received by the managed health care plan, consistent with actuarial certification, enrollment, and utilization, from the department pursuant to Section 14167.6.

(c) Any delegation or attempted delegation by a managed health care plan of its obligation to expend the capitation rate increases under this section shall not relieve the plan from its obligation to expend those capitation rate increases. Managed health care plans shall submit the documentation the department may require to demonstrate compliance with this subdivision. The documentation shall demonstrate actual expenditure of the capitation rate increases for hospital services, and not assignment to subcontractors of the managed health care plan's obligation of the duty to expend the capitation rate increases.

(d) The supplemental hospital payments made by managed health care plans pursuant to this section should reflect the overall purpose of this article.

(e) This article is not intended to create a private right of action by a hospital against a managed care plan, provided that the managed health care plan expends all increased capitation payments for hospital services.

SEC. 7. Article 5.226 (commencing with Section 14168.1) is added to Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code, to read:

Article 5.226. Medi-Cal Hospital Rate Stabilization Act of 2011

14168.1. For the purposes of this article, the following definitions shall apply:

(a) "Acute psychiatric days" means the total number of Short-Doyle administrative days, Short-Doyle acute care days, acute psychiatric administrative days, and acute psychiatric acute days identified in the Final Medi-Cal Utilization Statistics for the 2008–09 state fiscal year as calculated by the department on September 15, 2008.

(b) "Converted hospital" means a private hospital that becomes a designated public hospital or a nondesignated public hospital on or after January 1, 2011, a nondesignated public hospital that becomes a private hospital or a designated public hospital on or after January 1, 2011, or a designated public hospital that becomes a private hospital or a nondesignated public hospital on or after January 1, 2011.

(c) "Days data source" means the following:

(1) For a hospital that did not submit an Annual Financial Disclosure Report to the Office of Statewide Health Planning and Development for a fiscal year ending during 2007, but submitted that report for a fiscal period ending in 2008 that includes at least 10 months of 2007, the Annual Financial Disclosure Report submitted by the hospital to the Office of Statewide Health Planning and Development for the fiscal period in 2008 that includes at least 10 months of 2007.

(2) For a hospital owned by Kaiser Foundation Hospitals that submitted corrections to reported patient days to the Office of Statewide Health Planning and Development for its fiscal year ending in 2007 before July 31, 2009, the corrected data.

(3) For all other hospitals, the hospital's Annual Financial Disclosure Report in the Office of Statewide Health Planning and Development files as of October 31, 2008, for its fiscal year ending during 2007.

(d) "Designated public hospital" shall have the meaning given in subdivision (d) of Section 14166.1 as of January 1, 2011.

(e) "General acute care days" means the total number of Medi-Cal general acute care days paid by the department to a hospital in the 2008 calendar year, as reflected in the state paid claims files on July 10, 2009.

(f) "High acuity days" means Medi-Cal coronary care unit days, pediatric intensive care unit days, intensive care unit days, neonatal intensive care unit days, and burn unit days paid by the department during the 2008 calendar year, as reflected in the state paid claims files on July 10, 2009.

(g) "Hospital inpatient services" means all services covered under Medi-Cal and furnished by hospitals to patients who are admitted as hospital inpatients and reimbursed on a fee-for-service basis by the department directly or through its fiscal intermediary. Hospital inpatient services include outpatient services furnished by a hospital to a patient who is admitted to that hospital within 24 hours of the provision of the outpatient services that are related to the condition for which the patient is admitted. Hospital inpatient services do not include services for which a managed health care plan is financially responsible.

(h) "Hospital outpatient services" means all services covered under Medi-Cal furnished by hospitals to patients who are registered as hospital outpatients and reimbursed by the department on a fee-for-service basis directly or through its fiscal intermediary. Hospital outpatient services do not include services for which a managed health care plan is financially responsible, or services rendered by a hospital-based federally qualified health center for which reimbursement is received pursuant to Section 14132.100.

(i) "Individual hospital acute psychiatric supplemental payment" means the total amount of acute psychiatric hospital supplemental payments to a subject hospital for a quarter for which the supplemental payments are made. The "individual hospital acute psychiatric supplemental payment" shall be calculated for subject hospitals by multiplying the number of acute psychiatric days for the individual hospital for which a mental health plan was financially responsible by four hundred eighty-five dollars ($485) and dividing the result by four.

(j) (1) "Managed health care plan" means a health care delivery system that manages the provision of health care and receives prepaid capitated payments from the state in return for providing services to Medi-Cal beneficiaries.

(2) (A) Managed health care plans include county organized health systems and entities contracting with the department to provide services pursuant to two-plan models and geographic

managed care. Entities providing these services contract with the department pursuant to any of the following:

(i) Article 2.7 (commencing with Section 14087.3).

(ii) Article 2.8 (commencing with Section 14087.5).

(iii) Article 2.81 (commencing with Section 14087.96).

(iv) Article 2.91 (commencing with Section 14089).

(B) Managed health care plans do not include any of the following:

(i) Mental health plan contracting to provide mental health care for Medi-Cal beneficiaries pursuant to Part 2.5 (commencing with Section 5775) of Division 5.

(ii) Health plan not covering inpatient services such as primary care case management plans operating pursuant to Section 14088.85.

(iii) Long-Term Care Demonstration Projects for All-Inclusive Care for the Elderly operating pursuant to Chapter 8.75 (commencing with Section 14590).

(k) "Medi-Cal managed care days" means the total number of general acute care days, including well baby days, listed for the county organized health system and prepaid health plans identified in the Final Medi-Cal Utilization Statistics for the 2008–09 fiscal year, as calculated by the department on September 15, 2008, except that the general acute care days, including well baby days, for the Santa Barbara Health Care Initiative shall be derived from the Final Medi-Cal Utilization Statistics for the 2007–08 fiscal year.

(*l*) "Medicaid inpatient utilization rate" means Medicaid inpatient utilization rate as defined in Section 1396r-4 of Title 42 of the United States Code and as set forth in the final disproportionate share hospital eligibility list for the 2008–09 fiscal year released by the department on October 22, 2008.

(m) "Mental health plan" means a mental health plan that contracts with the State Department of Mental Health to furnish or arrange for the provision of mental health services to Medi-Cal beneficiaries pursuant to Part 2.5 (commencing with Section 5775) of Division 5.

(n) "New hospital" means a hospital operation, business, or facility functioning under current or prior ownership as a private hospital that does not have a days data source or a hospital that has a days data source in whole, or in part, from a previous operator

where there is an outstanding monetary liability owed to the state in connection with the Medi-Cal program and the new operator did not assume liability for the outstanding monetary obligation.

(o) "New noncontract hospital" means a private hospital that was a contract hospital on March 1, 2011, and elects to become a noncontract hospital at any time between March 1, 2011, and the end of the program period.

(p) "Nondesignated public hospital" means either of the following:

(1) A public hospital that is licensed under subdivision (a) of Section 1250 of the Health and Safety Code, is not designated as a specialty hospital in the hospital's annual financial disclosure report for the hospital's latest fiscal year ending in 2007, and satisfies the definition in paragraph (25) of subdivision (a) of Section 14105.98, excluding designated public hospitals.

(2) A tax-exempt nonprofit hospital that is licensed under subdivision (a) of Section 1250 of the Health and Safety Code, is not designated as a specialty hospital in the hospital's annual financial disclosure report for the hospital's latest fiscal year ending in 2007, is operating a hospital owned by a local health care district, and is affiliated with the health care district hospital owner by means of the district's status as the nonprofit corporation's sole corporate member.

(q) "Outpatient base amount" means the total amount of payments for hospital outpatient services made to a hospital in the 2007 calendar year, as reflected in state paid claims files on January 26, 2008.

(r) "Private hospital" means a hospital that meets all of the following conditions:

(1) Is licensed pursuant to subdivision (a) of Section 1250 of the Health and Safety Code.

(2) Is in the Charitable Research Hospital peer group, as set forth in the 1991 Hospital Peer Grouping Report published by the department, or is not designated as a specialty hospital in the hospital's Office of Statewide Health Planning and Development Annual Financial Disclosure Report for the hospital's latest fiscal year ending in 2007.

(3) Does not satisfy the Medicare criteria to be classified as a long-term care hospital.

(4) Is a nonpublic hospital, nonpublic converted hospital, or converted hospital as those terms are defined in paragraphs (26) to (28), inclusive, respectively, of subdivision (a) of Section 14105.98.

(s) "Program period" means the period from January 1, 2011, to June 30, 2011, inclusive.

(t) "Subject fiscal quarter" means a state fiscal quarter beginning on or after January 1, 2011, and ending before July 1, 2011.

(u) "Subject hospital" shall mean a hospital that meets all of the following conditions:

(1) Is licensed pursuant to subdivision (a) of Section 1250 of the Health and Safety Code.

(2) Is in the Charitable Research Hospital peer group, as set forth in the 1991 Hospital Peer Grouping Report published by the department, or is not designated as a specialty hospital in the hospital's Office of Statewide Health Planning and Development Annual Financial Disclosure Report for the hospital's latest fiscal year ending in 2007.

(3) Does not satisfy the Medicare criteria to be classified as a long-term care hospital.

(v) "Subject month" means a calendar month beginning on or after January 1, 2011, and ending before July 1, 2011.

(w) "Upper payment limit" means a federal upper payment limit on the amount of the Medicaid payment for which federal financial participation is available for a class of service and a class of health care providers, as specified in Part 447 of Title 42 of the Code of Federal Regulations.

14168.2. (a) Private hospitals shall be paid supplemental amounts for the provision of hospital outpatient services as set forth in this section. The supplemental amounts shall be in addition to any other amounts payable to hospitals with respect to those services and shall not affect any other payments to hospitals.

(b) Except as set forth in subdivisions (e) and (f), each private hospital shall be paid an amount for the program period equal to a percentage of the hospital's outpatient base amount. The percentage shall be the same for each hospital and shall result in payments to hospitals that equal the applicable federal upper payment limit, less any amounts paid pursuant to Section 14167.2 and accounted toward the federal upper payment limits for the entire 2010–11 fiscal year. For purposes of this subdivision the

applicable federal upper payment limit shall be the federal upper payment limit for hospital outpatient services furnished by private hospitals for the entire 2010–11 fiscal year.

(c) In the event federal financial participation is not available for all of the supplemental amounts payable to private hospitals under subdivision (b) due to the application of a federal upper payment limit or for any other reason, both of the following shall apply:

(1) The total amount payable to private hospitals under subdivision (b) for the subject fiscal year shall be reduced to the amount for which federal financial participation is available.

(2) The amount payable under subdivision (b) to each private hospital for the subject fiscal year shall be equal to the amount computed under subdivision (b) multiplied by the ratio of the total amount for which federal financial participation is available to the total amount computed under subdivision (b).

(d) The supplemental amounts set forth in this section are inclusive of federal financial participation.

(e) No payments shall be made under this section to a new hospital.

(f) No payments shall be made under this section to a converted hospital.

14168.3. (a) Private hospitals shall be paid supplemental amounts for the provision of hospital inpatient services as set forth in this section. The supplemental amounts shall be in addition to any other amounts payable to hospitals with respect to those services and shall not affect any other payments to hospitals.

(b) Except as set forth in subdivisions (g) and (h), each private hospital shall be paid 50 percent of the following amounts as applicable for the provision of hospital inpatient services for the program period:

(1) Nine hundred eleven dollars and forty-eight cents ($911.48) multiplied by the hospital's general acute care days.

(2) Four hundred eighty-five dollars ($485) multiplied by the hospital's acute psychiatric days that were paid directly by the department and were not the financial responsibility of a mental health plan.

(3) One thousand three hundred fifty dollars ($1,350) multiplied by the number of the hospital's high acuity days if the hospital's Medicaid inpatient utilization rate is less than 41.1 percent and

greater than 5 percent and at least 5 percent of the hospital's general acute care days are high acuity days. This amount shall be in addition to the amounts specified in paragraphs (1) and (2).

(4) One thousand three hundred fifty dollars ($1,350) multiplied by the number of the hospital's high acuity days if the hospital qualifies to receive the amount set forth in paragraph (3) and has been designated as a Level I, Level II, Adult/Ped Level I, or Adult/Ped Level II trauma center by the Emergency Medical Services Authority established pursuant to Section 1797.1 of the Health and Safety Code. This amount shall be in addition to the amounts specified in paragraphs (1), (2), and (3).

(c) A private hospital that provides Medi-Cal subacute services during the program period and has a Medicaid inpatient utilization rate that is greater than 5 percent and less than 41.1 percent shall be paid a supplemental amount equal to 20 percent of the Medi-Cal subacute payments made to the hospital during the 2008 calendar year.

(d) (1) In the event federal financial participation is not available for all of the supplemental amounts payable to private hospitals under subdivision (b) due to the application of a federal upper payment limit or for any other reason, both of the following shall apply:

(A) The total amount payable to private hospitals under subdivision (b) shall be reduced to reflect the amount for which federal financial participation is available.

(B) The amount payable under subdivision (b) to each private hospital shall be equal to the amount computed under subdivision (b) multiplied by the ratio of the total amount for which federal financial participation is available to the total amount computed under subdivision (b).

(2) In the event federal financial participation is not available for all of the supplemental amounts payable to private hospitals under subdivision (c) due to the application of a federal upper payment limit or for any other reason, both of the following shall apply:

(A) The total amount payable to private hospitals under subdivision (c) shall be reduced to reflect the amount for which federal financial participation is available.

(B) The amount payable under subdivision (c) to each private hospital shall be equal to the amount computed under subdivision

(c) multiplied by the ratio of the total amount for which federal financial participation is available to the total amount computed under subdivision (c).

(e) In the event the amount otherwise payable to a hospital under this section exceeds the amount for which federal financial participation is available for that hospital, the amount due to the hospital shall be reduced to the amount for which federal financial participation is available.

(f) The amounts set forth in this section are inclusive of federal financial participation.

(g) No payments shall be made under this section to a new hospital.

(h) No payments shall be made under this section to a converted hospital.

(i) (1) The department shall increase payments to mental health plans for the program period exclusively for the purpose of making payments to hospitals. The aggregate amount of the increased payments for a subject fiscal quarter shall be the total of the individual hospital acute psychiatric supplemental payment amounts for all hospitals for which federal financial participation is available.

(2) The payments described in paragraph (1) may be made directly by the department to hospitals when federal law does not require that the payments be transmitted to hospitals via mental health plans.

14168.5. (a) The department shall increase capitation payments to Medi-Cal managed health care plans for the program period as set forth in this section.

(b) The increased capitation payments shall be made as part of the monthly capitated payments made by the department to managed health care plans.

(c) The aggregate amount of increased capitation payments to all Medi-Cal managed health care plans for the program period shall be three hundred twenty-three million six hundred forty-nine thousand eight hundred fifty seven dollars ($323,649,857), or the maximum amount for which federal financial participation is available, whichever is lower.

(d) The department shall determine the amount of the increased capitation payments for each managed health care plan. The department shall consider the composition of Medi-Cal enrollees

in the plan, the anticipated utilization of hospital services by the plan's Medi-Cal enrollees, and other factors that the department determines are reasonable and appropriate to ensuring access to high-quality hospital services by the plan's enrollees.

(e) The amount of increased capitation payments to each Medi-Cal managed care health plan shall not exceed an amount that results in capitation payments that are certified by the state's actuary as meeting federal requirements, taking into account the requirement that all of the increased capitation payments under this section shall be paid by the Medi-Cal managed health care plans to hospitals for hospital services to Medi-Cal enrollees of the plan.

(f) (1) The increased capitation payments to managed health care plans under this section shall be made to support the availability of hospital services and ensure access to hospital services for Medi-Cal beneficiaries. The increased capitation payments to managed health care plans shall commence no later than June 30, 2011, or within 60 days of the date on which all necessary federal approvals have been received, and shall include, but not be limited to, the sum of the increased payments for all prior months for which payments are due.

(2) To secure the necessary funding for the payment or payments made pursuant to paragraph (1), the department may accumulate funds in the Hospital Quality Assurance Revenue Fund for the purpose of funding managed care capitation payments under this article regardless of the date on which capitation payments are scheduled to be paid in order to secure the necessary total funding for managed care payments by June 30, 2011. To the extent feasible, the funds shall be accumulated as follows, provided that the department may adjust the following dates and amounts as necessary to accumulate sufficient funding by June 1, 2011:

(A) Fifty percent of total necessary funding shall be accumulated from the first payment of quality assurance fees received from the hospitals and made pursuant to Article 5.227 (commencing with Section 14168.31).

(B) Fifty percent of total funding necessary shall be retained from the final payment of quality assurance fees received from the hospitals and made pursuant to Article 5.227 (commencing with Section 14168.31).

(g) Payments to managed health care plans that would be paid consistent with actuarial certification and enrollment in the absence of the payments made pursuant to this section shall not be reduced as a consequence of payment under this section.

(h) (1) Each managed health care plan shall expend 100 percent of any increased capitation payments it receives under this section on hospital services.

(2) The department may issue change orders to amend contracts with managed health care plans as needed to adjust monthly capitation payments in order to implement this section.

(3) For entities contracting with the department pursuant to Article 2.91 (commencing with Section 14089), any incremental increase in capitation rates pursuant to this section shall not be subject to negotiation and approval by the California Medical Assistance Commission.

(i) In the event federal financial participation is not available for all of the increased capitation payments determined for a month pursuant to this section for any reason, the increased capitation payments mandated by this section for that month shall be reduced proportionately to the amount for which federal financial participation is available.

(j) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department shall implement this section by means of policy letters or similar instructions, without taking further regulatory action.

14168.6. (a) Each managed health care plan receiving increased capitation payments under Section 14168.5 shall expend the capitation rate increases in a manner consistent with actuarial certification, enrollment, and utilization on hospital services. Each managed health care plan shall expend increased capitation payments on hospital services within 30 days of receiving the increased capitation payments to the extent they are made for a subject month that is prior to the date on which the payments are received by the managed health care plan.

(b) The sum of all expenditures made by a managed health care plan for hospital services pursuant to this section shall equal, or approximately equal, all increased capitation payments received by the managed health care plan, consistent with actuarial

certification, enrollment, and utilization, from the department pursuant to Section 14168.5.

(c) Any delegation or attempted delegation by a managed health care plan of its obligation to expend the capitation rate increases under this section shall not relieve the plan from its obligation to expend those capitation rate increases. Managed health care plans shall submit the documentation the department may require to demonstrate compliance with this subdivision. The documentation shall demonstrate actual expenditure of the capitation rate increases for hospital services, and not assignment to subcontractors of the managed health care plan's obligation of the duty to expend the capitation rate increases.

(d) The supplemental hospital payments made by managed health care plans pursuant to this section shall reflect the overall purpose of the act.

(e) This article is not intended to create a private right of action by a hospital against a managed care plan provided that the managed health care plan expends all increased capitation payments for hospital services.

14168.7. (a) The department shall design and implement, in consultation with designated and nondesignated public hospitals, an IGT program relating to Medi-Cal managed care services provided by designated and nondesignated public hospitals in order to increase capitation payments for the purpose of increasing their reimbursement.

(b) For purposes of this section, the department shall follow the requirements as specified in subdivision (f) of Section 14165.57.

(c) The increased capitation payments under this section shall be actuarially sound and, in regard to the payments for nondesignated public hospitals, shall be in proportion to the intergovernmental transfers pursuant to Section 14165.57 in order to help maximize reimbursement for designated and nondesignated public hospitals to the extent permissible under federal law.

(d) This section shall be implemented on the later of June 30, 2011, or the date on which all necessary federal approvals have been received.

(e) Participation in the intergovernmental transfers under this section is voluntary on the part of the transferring entities for the purposes of all applicable federal laws.

(f) This section shall be implemented only to the extent federal financial participation is available for the reimbursement specified in subdivision (a).

(g) This section shall be implemented only to the extent federal financial participation is not jeopardized.

(h) To the extent that the director determines that the payments do not comply with the federal Medicaid requirements, the director retains the discretion not to implement an intergovernmental transfer and may adjust the payment as necessary to comply with federal Medicaid requirements.

(i) To the extent federal approval is secured, the increased capitation payments under this section may cover services for periods beginning on or after July 1, 2011.

(j) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department shall implement this section by means of policy letters or similar instructions, without taking further regulatory action.

14168.8. (a) The amount of any payments made under this article to private hospitals, including the amount of payments made under Sections 14168.2 and 14168.3 and additional payments to private hospitals by managed health care plans pursuant to Section 14168.5, shall not be included in the calculation of the low-income percent or the OBRA 1993 payment limitation, as defined in paragraph (24) of subdivision (a) of Section 14105.98, for purposes of determining payments to private hospitals.

(b) The amount of any payments made to a hospital under this article shall not be included in the calculation of stabilization funding under Article 5.2 (commencing with Section 14166) or any successor legislation, including legislation implementing California's Bridge to Reform Section 1115(a) Medicaid Demonstration (11-W-00193/9).

14168.9. The payments to a hospital under this article shall not be made for any portion of the program period during which the hospital is closed. A hospital shall be deemed to be closed on the first day of any period during which the hospital has no acute inpatients for at least 30 consecutive days. Payments under this article to a hospital that is closed during any portion of the program period shall be reduced by applying a fraction, expressed as a percentage, the numerator of which shall be the number of days

during the program period that the hospital is closed and the denominator of which shall be 181.

14168.10. (a) The amount of any supplemental payment under this article for a new noncontract hospital shall be reduced by the amount by which that hospital's overall payment for services for Medi-Cal patients during the program period was increased by reason of its becoming a noncontract hospital.

(b) The amount of the nonfederal share of any supplemental payment reduction under subdivision (a) shall be transferred from the Hospital Quality Assurance Revenue Fund to the General Fund at the time the reduced supplemental payment under subdivision (a) is made.

(c) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department shall implement this section by means of policy letters or similar instructions, without taking further regulatory action.

14168.11. The department shall make disbursements from the Hospital Quality Assurance Revenue Fund consistent with the following:

(a) Fund disbursements shall be made periodically within 15 days of each date on which quality assurance fees are due from hospitals.

(b) The funds shall be disbursed in accordance with the order of priority set forth in subdivision (b) of Section 14168.33, subject to the following:

(1) The amount disbursed for children's health coverage shall not exceed one hundred five million dollars ($105,000,000) until at least one-half of the aggregate supplemental payments to hospitals due under Sections 14168.2 and 14168.3 are made.

(2) Funds may be set aside for increased capitation payment to managed care health plans pursuant to subdivision (f) of Section 14168.5.

(c) The funds shall be disbursed in each payment cycle in accordance with the order of priority set forth in subdivision (b) of Section 14168.33 as modified by subdivision (b), and so that the supplemental payments to hospitals, increased capitation payment to managed health care plans, and increased payments to mental health plans, and direct payments to hospitals of acute

psychiatric supplemental payments are made to the maximum extent for which funds are available.

(d) To the maximum extent possible, consistent with the availability of funds in the quality assurance fund and the timing of federal approvals, the supplemental payments to hospitals, increased capitation payments to managed health care plans, and increased payments to mental health plans under this article shall be made before July 1, 2011.

(e) The aggregate amount of funds to be disbursed to private hospitals shall be determined under Sections 14168.2 and 14168.3. The aggregate amount of funds to be disbursed to managed health care plans shall be determined under Section 14168.5.

14168.12. (a) Exclusive of payments made under Article 5.21, payment rates for hospital outpatient services, furnished by private hospitals, nondesignated public hospitals, and designated public hospitals before July 1, 2011, exclusive of amounts payable under this article, shall not be reduced below the rates in effect on January 1, 2011.

(b) Rates payable to hospitals for hospital inpatient services furnished before January 1, 2011, under contracts negotiated pursuant to the Selective Provider Contracting Program shall not be reduced below the lower of the contract rates in effect on January 1, 2010, or the contract rates in effect on July 1, 2010. This subdivision shall not prohibit changes to the supplemental payments paid to individual hospitals under Sections 14166.12, 14166.17, and 14166.23, provided that the aggregate amount of the payments for the 2010–11 fiscal year are not less than the minimum amount permitted under Section 14167.13.

(c) Subject to Section 14105.281, exclusive of payments made under Article 5.21, payments to private hospitals for hospital inpatient services furnished before July 1, 2011, that are not reimbursed under a contract negotiated pursuant to the Selective Provider Contracting Program, exclusive of amounts payable under this article, shall not be less than the amount of payments that would have been made under the payment methodology in effect on the effective date of this article.

(d) Solely for purposes of this article, a rate reduction or a change in a rate methodology that is enjoined by a court shall be included in the determination of a rate or a rate methodology until all appeals or judicial review have been exhausted and the rate

reduction or change in rate methodology has been permanently enjoined, denied by the federal government, or otherwise permanently prevented from being implemented.

14168.13. (a) The director shall do all of the following:

(1) Promptly submit any state plan amendment or waiver request that may be necessary to implement this article.

(2) Promptly seek federal approvals or waivers as may be necessary to implement this article and to obtain federal financial participation to the maximum extent possible for the payments under this article.

(3) Amend the contracts between the managed health care plans and the department as necessary to incorporate the provisions of Sections 14168.5 and 14168.6 and promptly seek all necessary federal approvals of those amendments. The department shall pursue amendments to the contracts as soon as possible after the effective date of this article and Article 5.227 (commencing with Section 14168.31), and shall not wait for federal approval of this article or Article 5.227 (commencing with Section 14168.31) prior to pursuing amendments to the contracts. The amendments to the contracts shall, among other provisions, set forth an agreement to increase capitation payments to managed health care plans under Section 14168.5 and increase payments to hospitals under Section 14168.6 in a manner that relates back to January 1, 2011, or as soon thereafter as possible, conditioned on obtaining all federal approvals necessary for federal financial participation for the increased capitation payments to the managed health care plans.

(b) In implementing this article, the department may utilize the services of the Medi-Cal fiscal intermediary through a change order to the fiscal intermediary contract to administer this program, consistent with the requirements of Sections 14104.6, 14104.7, 14104.8, and 14104.9. Contracts entered into for purposes of implementing this article or Article 5.227 (commencing with Section 14168.31) shall not be subject to Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code.

(c) This article shall become inoperative if either of the following occurs:

(1) In the event, and on the effective date, of a final judicial determination made by any court of appellate jurisdiction or a final determination by the federal Department of Health and Human Services or the federal Centers for Medicare and Medicaid Services

that any element of this article or any provision of Section 14166.115 cannot be implemented.

(2) In the event both of the following conditions exist:

(A) The federal Centers for Medicare and Medicaid Services denies approval for, or does not approve before January 1, 2012, the implementation of Article 5.227 (commencing with Section 14168.31) or this article.

(B) Either or both articles cannot be modified by the department pursuant to subdivision (e) of Section 14168.33 in order to meet the requirements of federal law or to obtain federal approval.

(d) If this article becomes inoperative pursuant to paragraph (1) of subdivision (c) and the determination applies to any period or periods of time prior to the effective date of the determination, the department shall have authority to recoup all payments made pursuant to this article during that period or those periods of time.

(e) In the event any hospital, or any party on behalf of a hospital, shall initiate a case or proceeding in any state or federal court in which the hospital seeks any relief of any sort whatsoever, including, but not limited to, monetary relief, injunctive relief, declaratory relief, or a writ, based in whole or in part on a contention that any or all of this article is unlawful and may not be lawfully implemented, both of the following shall apply:

(1) No payments shall be made to the hospital pursuant to this article until the case or proceeding is finally resolved, including the final disposition of all appeals.

(2) Any amount computed to be payable to the hospital pursuant to this section for a project year shall be withheld by the department and shall be paid to the hospital only after the case or proceeding is finally resolved, including the final disposition of all appeals.

(f) Subject to Section 14168.34, no payment shall be made under this article until all necessary federal approvals for the payment and for the fee provisions in Article 5.227 (commencing with Section 14168.31) have been obtained and the fee has been imposed and collected. Notwithstanding any other provision of law, payments under this article shall be made only to the extent that the fee established in Article 5.227 (commencing with Section 14168.31) is collected and available to cover the nonfederal share of the payments.

(g) A hospital’s receipt of payments under this article for services rendered prior to the effective date of this article is

conditioned on the hospital's continued participation in Medi-Cal for at least 30 days after the effective date of this article.

(h) All payments made by the department to hospitals, managed health care plans, and mental health plans under this article shall be made only from the following:

(1) The quality assurance fee set forth in Article 5.227 (commencing with Section 14168.31) and due and payable on or before June 30, 2011, along with any interest or other investment income thereon.

(2) Federal reimbursement and any other related federal funds.

14168.14. Notwithstanding any other provision of this article or Article 5.227 (commencing with Section 14168.31), the director may proportionately reduce the amount of any supplemental payments, increased capitation payments, or grants under this article to the extent that the payment or grant would result in the reduction of other amounts payable to a hospital or managed health care plan or mental health plan due to the application of federal law.

14168.15. The director may, pursuant to Section 14168.40, decide not to implement or to discontinue implementation of this article and Article 5.227 (commencing with Section 14168.31), and to retroactively invalidate the requirements for supplemental payments or other payments under this article.

14168.16. This article shall remain in effect only until January 1, 2013, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2013, deletes or extends that date.

14168.17. Notwithstanding any other provision of law, if federal approval or a letter that indicates likely federal approval in accordance with Section 14168.34 has not been received on or before June 1, 2011, then this article shall become inoperative, and as of June 1, 2011, is repealed, unless a later enacted statute, that is enacted before June 1, 2011, deletes or extends that date.

14168.175. Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department shall implement this article by means of policy letters or similar instructions, without taking further regulatory action.

SEC. 8. Article 5.227 (commencing with Section 14168.31) is added to Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code, to read:

Article 5.227. Hospital Quality Assurance Fee Act of 2011

14168.31. For the purposes of this article, the following definitions shall apply:

(a) (1) "Aggregate quality assurance fee" means, with respect to a hospital that is not a prepaid health plan hospital, the sum of all of the following:

(A) The annual fee-for-service days for an individual hospital multiplied by the fee-for-service per diem quality assurance fee rate, divided by two.

(B) The annual managed care days for an individual hospital multiplied by the managed care per diem quality assurance fee rate, divided by two.

(C) The annual Medi-Cal days for an individual hospital multiplied by the Medi-Cal per diem quality assurance fee rate, divided by two.

(2) "Aggregate quality assurance fee" means, with respect to a hospital that is a prepaid health plan hospital, the sum of all of the following:

(A) The annual fee-for-service days for an individual hospital multiplied by the fee-for-service per diem quality assurance fee rate, divided by two.

(B) The annual managed care days for an individual hospital multiplied by the prepaid health plan hospital managed care per diem quality assurance fee rate, divided by two.

(C) The annual Medi-Cal managed care days for an individual hospital multiplied by the prepaid health plan hospital Medi-Cal managed care per diem quality assurance fee rate, divided by two.

(D) The annual Medi-Cal fee-for-service days for an individual hospital multiplied by the Medi-Cal per diem quality assurance fee rate, divided by two.

(3) "Aggregate quality assurance fee after the application of the fee percentage" means the aggregate quality assurance fee multiplied by the fee percentage for the program period.

(b) "Annual fee-for-service days" means the number of fee-for-service days of each hospital subject to the quality assurance fee, as reported on the day's data source.

(c) "Annual managed care days" means the number of managed care days of each hospital subject to the quality assurance fee, as reported on the day's data source.

(d) "Annual Medi-Cal days" means the number of Medi-Cal days of each hospital subject to the quality assurance fee, as reported on the day's data source.

(e) "Converted hospital" shall mean a hospital described in subdivision (b) of Section 14168.1.

(f) "Days data source" means the following:

(1) For a hospital that did not submit an Annual Financial Disclosure Report to the Office of Statewide Health Planning and Development for a fiscal year ending during 2007, but submitted that report for a fiscal period ending in 2008 that includes at least 10 months of 2007, the Annual Financial Disclosure Report submitted by the hospital to the Office of Statewide Health Planning and Development for the fiscal period in 2008 that includes at least 10 months of 2007.

(2) For a hospital owned by Kaiser Foundation Hospitals that submitted corrections to reported patient days to the Office of Statewide Health Planning and Development for its fiscal year ending in 2007 before July 31, 2009, the corrected data.

(3) For all other hospitals, the hospital's Annual Financial Disclosure Report in the Office of Statewide Health Planning and Development files as of October 31, 2008, for its fiscal year ending during 2007.

(g) "Designated public hospital" shall have the meaning given in subdivision (d) of Section 14166.1 as of January 1, 2011.

(h) "Exempt facility" means any of the following:

(1) A public hospital, which shall include either of the following:

(A) A hospital, as defined in paragraph (25) of subdivision (a) of Section 14105.98.

(B) A tax-exempt nonprofit hospital that is licensed under subdivision (a) of Section 1250 of the Health and Safety Code and operating a hospital owned by a local health care district, and is affiliated with the health care district hospital owner by means of the district's status as the nonprofit corporation's sole corporate member.

(2) With the exception of a hospital that is in the Charitable Research Hospital peer group, as set forth in the 1991 Hospital Peer Grouping Report published by the department, a hospital that is a hospital designated as a specialty hospital in the hospital's Office of Statewide Health Planning and Development Hospital Annual Disclosure Report for the hospital's fiscal year ending in the 2007 calendar year.

(3) A hospital that satisfies the Medicare criteria to be a long-term care hospital.

(4) A small and rural hospital as specified in Section 124840 of the Health and Safety Code designated as that in the hospital's Office of Statewide Health Planning and Development Hospital Annual Disclosure Report for the hospital's fiscal year ending in the 2007 calendar year.

(i) "Federal approval" means the last approval by the federal government required for the implementation of this article and Article 5.226 (commencing with Section 14168.1).

(j) (1) "Fee-for-service per diem quality assurance fee rate" means a fixed daily fee on fee-for-service days.

(2) The fee-for-service per diem quality assurance fee rate must be no greater than or equal to two hundred fifty-three dollars and twenty-nine cents ($253.29) per day.

(3) Upon federal approval or conditional federal approval described in Section 14168.34, the director shall determine the fee-for-service per diem quality assurance fee rate based on the funds required to make the payments specified in Article 5.226 (commencing with Section 14168.1), in consultation with the hospital community.

(k) "Fee-for-service days" means inpatient hospital days where the service type is reported as "acute care," "psychiatric care," and "chemical dependency care and rehabilitation care," and the payer category is reported as "Medicare traditional," "county indigent programs-traditional," "other third parties-traditional," "other indigent," and "other payers," for purposes of the Annual Financial Disclosure Report submitted by hospitals to the Office of Statewide Health Planning and Development.

(*l*) "Fee percentage" means a fraction, expressed as a percentage, the numerator of which is the amount of payments for the program period under Sections 14168.2, 14168.3, and 14168.5, for which federal financial participation is available and the denominator of

which is one billion eight hundred ninety nine million eight hundred eleven thousand one hundred eighty three dollars ($1,899,811,183).

(m) "General acute care hospital" means any hospital licensed pursuant to subdivision (a) of Section 1250 of the Health and Safety Code.

(n) "Hospital community" means any hospital industry organization or system that represents children's hospitals, nondesignated public hospitals, designated public hospitals, private safety-net hospitals, and other public or private hospitals.

(o) "Managed care days" means inpatient hospital days where the service type is reported as "acute care," "psychiatric care," and "chemical dependency care and rehabilitation care," and the payer category is reported as "Medicare managed care," "county indigent programs-managed care," and "other third parties-managed care," for purposes of the Annual Financial Disclosure Report submitted by hospitals to the Office of Statewide Health Planning and Development.

(p) "Managed care per diem quality assurance fee rate" means a fixed fee on managed care days of twenty-seven dollars and twenty-five cents ($27.25) per day.

(q) "Medi-Cal days" means inpatient hospital days where the service type is reported as "acute care," "psychiatric care," and "chemical dependency care and rehabilitation care," and the payer category is reported as "Medi-Cal traditional" and "Medi-Cal managed care," for purposes of the Annual Financial Disclosure Report submitted by hospitals to the Office of Statewide Health Planning and Development.

(r) "Medi-Cal fee-for-service days" means inpatient hospital days where the service type is reported as "acute care," "psychiatric care," and "chemical dependency care and rehabilitation care," and the payer category is reported as "Medi-Cal traditional" for purposes of the Annual Financial Disclosure Report submitted by hospitals to the Office of Statewide Health Planning and Development.

(s) "Medi-Cal managed care days" means inpatient hospital days as reported on the days data source where the service type is reported as "acute care," "psychiatric care," and "chemical dependency care and rehabilitation care," and the payer category is reported as "Medi-Cal managed care" for purposes of the Annual

Financial Disclosure Report submitted by hospitals to the Office of Statewide Health Planning and Development.

(t) "Medi-Cal per diem quality assurance fee rate" means a fixed fee on Medi-Cal days of two hundred seventy-five dollars ($275) per day.

(u) "New hospital" means a hospital operation, business, or facility functioning under current or prior ownership as a private hospital that does not have a days data source or a hospital that has a days data source in whole, or in part, from a previous operator where there is an outstanding monetary liability owed to the state in connection with the Medi-Cal program and the new operator did not assume liability for the outstanding monetary obligation.

(v) "Nondesignated public hospital" means either of the following:

(1) A public hospital that is licensed under subdivision (a) of Section 1250 of the Health and Safety Code, is not designated as a specialty hospital in the hospital's annual financial disclosure report for the hospital's latest fiscal year ending in 2007, and satisfies the definition in paragraph (25) of subdivision (a) of Section 14105.98, excluding designated public hospitals.

(2) A tax-exempt nonprofit hospital that is licensed under subdivision (a) of Section 1250 of the Health and Safety Code, is not designated as a specialty hospital in the hospital's annual financial disclosure report for the hospital's latest fiscal year ending in 2007, is operating a hospital owned by a local health care district, and is affiliated with the health care district hospital owner by means of the district's status as the nonprofit corporation's sole corporate member.

(w) "Prepaid health plan hospital" means a hospital owned by a nonprofit public benefit corporation that shares a common board of directors with a nonprofit health care service plan.

(x) "Prepaid health plan hospital managed care per diem quality assurance fee rate" means a fixed fee on non-Medi-Cal managed care days for prepaid health plan hospitals of fifteen dollars and twenty-six cents ($15.26) per day.

(y) "Prepaid health plan hospital Medi-Cal managed care per diem quality assurance fee rate" means a fixed fee on Medi-Cal managed care days for prepaid health plan hospitals of one hundred fifty-four dollars ($154) per day.

(z) "Prior fiscal year data" means any data taken from sources that the department determines are the most accurate and reliable at the time the determination is made, or may be calculated from the most recent audited data using appropriate update factors. The data may be from prior fiscal years, current fiscal years, or projections of future fiscal years.

(aa) "Private hospital" means a hospital that meets all of the following conditions:

(1) Is licensed pursuant to subdivision (a) of Section 1250 of the Health and Safety Code.

(2) Is in the Charitable Research Hospital peer group, as set forth in the 1991 Hospital Peer Grouping Report published by the department, or is not designated as a specialty hospital in the hospital's Office of Statewide Health Planning and Development Annual Financial Disclosure Report for the hospital's latest fiscal year ending in 2007.

(3) Does not satisfy the Medicare criteria to be classified as a long-term care hospital.

(4) Is a nonpublic hospital, nonpublic converted hospital, or converted hospital as those terms are defined in paragraphs (26) to (28), inclusive, respectively, of subdivision (a) of Section 14105.98.

(ab) "Program period" means the period from January 1, 2011, to June 30, 2011, inclusive.

(ac) "Subject fiscal quarter" means a state fiscal quarter during the program period.

(ad) "Upper payment limit" means a federal upper payment limit on the amount of the Medicaid payment for which federal financial participation is available for a class of service and a class of health care providers, as specified in Part 447 of Title 42 of the Code of Federal Regulations.

14168.32. (a) There shall be imposed on each general acute care hospital that is not an exempt facility a quality assurance fee, provided that a quality assurance fee under this article shall not be imposed on a converted hospital.

(b) The quality assurance fee shall be computed starting on January 1, 2011, and continue through and including June 30, 2011.

(c) Subject to Section 14168.34, upon receipt of federal approval, the following shall become operative:

(1) Within 10 business days following receipt of the notice of federal approval from the federal government, the department shall send notice to each hospital subject to the quality assurance fee, and publish on its Internet Web site, the following information:

(A) The date that the state received notice of federal approval.

(B) The fee percentage for the program period.

(2) The notice to each hospital subject to the quality assurance fee shall also state the following:

(A) The aggregate quality assurance fee after the application of the fee percentage for the program period.

(B) The aggregate quality assurance fee.

(C) The amount of each payment due from the hospital with respect to the aggregate quality assurance fee.

(D) The date on which each payment is due.

(3) The hospitals shall pay the aggregate quality assurance fee, as follows:

(A) If the notice of federal approval is received before March 15, 2011, the aggregate quality assurance fee shall be paid on or before the later of March 1, 2011, or the fifth day after the receipt of the notice of federal approval.

(B) If the notice of federal approval is received on or after March 15, 2011, the aggregate quality assurance fee shall be made in one or more payments. The payments shall be made on the sixth of each month on or after the date federal approval is received and June 6, 2011.

(4) Notwithstanding paragraph (3), the amount of each hospital's aggregate quality assurance fee after the application of the fee percentage that has not been paid by the hospital before June 15, 2011, pursuant to paragraph (3), shall be paid by the hospital no later than June 15, 2011.

(d) The quality assurance fee, as paid pursuant to this section, shall be paid by each hospital subject to the fee to the department for deposit in the Hospital Quality Assurance Revenue Fund. Deposits may be accepted at any time and will be credited toward the program period.

(e) This section shall become inoperative if the federal Centers for Medicare and Medicaid Services denies approval for, or does not approve before January 1, 2012, the implementation of this article or Article 5.226 (commencing with Section 14168.1), and either or both articles cannot be modified by the department

pursuant to subdivision (d) of Section 14168.33 in order to meet the requirements of federal law or to obtain federal approval.

(f) In no case shall the aggregate fees collected in a federal fiscal year pursuant to this section and Section 14167.32 exceed the maximum percentage of the annual aggregate net patient revenue for hospitals subject to the fee that is prescribed pursuant to federal law and regulations as necessary to preclude a finding that an indirect guarantee has been created.

(g) (1) Interest shall be assessed on quality assurance fees not paid on the date due at the greater of 10 percent per annum or the rate at which the department assesses interest on Medi-Cal program overpayments to hospitals that are not repaid when due. Interest shall begin to accrue the day after the date the payment was due and shall be deposited in the Hospital Quality Assurance Revenue Fund.

(2) In the event that any fee payment is more than 60 days overdue, a penalty equal to the interest charge described in paragraph (1) shall be assessed and due for each month for which the payment is not received after 60 days.

(h) When a hospital fails to pay all or part of the quality assurance fee on or before the date that payment is due, the department may the following day immediately begin to deduct the unpaid assessment and interest owed from any Medi-Cal payments or other state payments to the hospital in accordance with Section 12419.5 of the Government Code until the full amount is recovered. All amounts, except penalties, deducted by the department under this subdivision shall be deposited in the Hospital Quality Assurance Revenue Fund. The remedy provided to the department by this section is in addition to other remedies available under law.

(i) The payment of the quality assurance fee shall not be considered as an allowable cost for Medi-Cal cost reporting and reimbursement purposes.

(j) The department shall work in consultation with the hospital community to implement this article and Article 5.226 (commencing with Section 14168.1).

(k) This subdivision creates a contractually enforceable promise on behalf of the state to use the proceeds of the quality assurance fee, including any federal matching funds, solely and exclusively for the purposes set forth in this article as they existed on the

effective date of this article, to limit the amount of the proceeds of the quality assurance fee to be used to pay for the health care coverage of children to the amounts specified in this article, to limit any payments for the department's costs of administration to the amounts set forth in this article on the effective date of this article, to maintain and continue prior reimbursement levels as set forth in Section 14168.14 on the effective date of that article, and to otherwise comply with all its obligations set forth in Article 5.226 (commencing with Section 14168.1) and this article provided that amendments that arise from, or have as a basis, a decision, advice, or determination by the federal Centers for Medicare and Medicaid Services relating to federal approval of the quality assurance fee or the payments set forth in this article or Article 5.226 (commencing with Section 14168.1) shall control for the purposes of this subdivision.

(*l*) For the purpose of this article, references to the receipt of notice by the state of federal approval of the implementation of this article shall refer to the last date that the state receives notice of all federal approval or waivers required for implementation of this article and Article 5.226 (commencing with Section 14168.1).

(m) (1) Effective July 1, 2011, the rates payable to hospitals and managed health care plans under Medi-Cal shall be the rates then payable without the supplemental and increased capitation payments set forth in Article 5.226 (commencing with Section 14168.1).

(2) The supplemental payments and other payments under Article 5.226 (commencing with Section 14168.1) shall be regarded as quality assurance payments, the implementation or suspension of which does not affect a determination of the adequacy of any rates under federal law.

(n) (1) Subject to paragraph (2), the director may waive any or all interest and penalties assessed under this article in the event that the director determines, in his or her sole discretion, that the hospital has demonstrated that imposition of the full quality assurance fee on the timelines applicable under this article has a high likelihood of creating a financial hardship for the hospital or a significant danger of reducing the provision of needed health care services.

(2) Waiver of some or all of the interest or penalties under this subdivision shall be conditioned on the hospital's agreement to

make fee payments, or to have the payments withheld from payments otherwise due from the Medi-Cal program to the hospital, on a schedule developed by the department that takes into account the financial situation of the hospital and the potential impact on services.

(3) A decision by the director under this subdivision shall not be subject to judicial review.

(4) If fee payments are remitted to the department after the date determined by the department to be the final date for calculating the final supplemental payments under this article and Article 5.226 (commencing with Section 14168.1), the fee payments shall be retained in the fund for purposes of funding supplemental payments supported by a hospital quality assurance fee program implemented under subsequent legislation, provided however that if supplemental payments are not implemented under subsequent legislation, then those fee payments shall be deposited to the Distressed Hospital Fund.

(5) If during the implementation of this article, fee payments that were due under Articles 5.21 and 5.22 are remitted to the department under a payment plan or for any other reason, and the final date for calculating the final supplemental payments under Articles 5.21 and 5.22 has passed, then those fee payments shall be deposited to the fund to support the uses established by this article.

14168.33. (a) (1) All fees required to be paid to the state pursuant to this article shall be paid in the form of remittances payable to the department.

(2) The department shall directly transmit the fee payments to the Treasurer to be deposited in the Hospital Quality Assurance Revenue Fund, created pursuant to Section 14167.35. Notwithstanding Section 16305.7 of the Government Code, any interest and dividends earned on deposits in the fund from the proceeds of the fee assessed pursuant to this article shall be retained in the fund for purposes specified in subdivision (b).

(b) Notwithstanding subdivision (c) of Section 14167.35, all funds from the proceeds of the fee assessed pursuant to this article in the Hospital Quality Assurance Revenue Fund, together with any interest and dividends earned on money in the fund, shall, upon appropriation by the Legislature, continue to be used exclusively to enhance federal financial participation for hospital

services under the Medi-Cal program, to provide additional reimbursement to, and to support quality improvement efforts of, hospitals, and to minimize uncompensated care provided by hospitals to uninsured patients, in the following order of priority:

(1) To pay for the department's staffing and administrative costs directly attributable to implementing Article 5.226 (commencing with Section 14168.1) and this article, not to exceed five hundred thousand dollars ($500,000).

(2) To pay for the health care coverage for children in the amount of one hundred five million dollars ($105,000,000) for each subject fiscal quarter for which payments are made under Article 5.226 (commencing with Section 14168.1).

(3) To make increased capitation payments to managed health care plans pursuant to Article 5.226 (commencing with Section 14168.1).

(4) To reimburse the General Fund for the increase in the overall compensation to a private hospital that is attributable to its change in status from contract hospital to noncontract hospital, pursuant to subdivision (a) of Section 14168.10.

(5) To make increased payments to hospitals pursuant to Article 5.226 (commencing with Section 14168.1).

(6) To make increased payments to mental health plans pursuant to Article 5.226 (commencing with Section 14168.1).

(c) Any amounts of the quality assurance fee collected in excess of the funds required to implement subdivision (b), including any funds recovered under subdivision (d) of Section 14168.13 or subdivision (e) of Section 14168.38, shall be refunded to general acute care hospitals, pro rata with the amount of quality assurance fee paid by the hospital, subject to the limitations of federal law. If federal rules prohibit the refund described in this subdivision, the excess funds shall be deposited in the Distressed Hospital Fund to be used for the purposes described in Section 14166.23, and shall be supplemental to and not supplant existing funds.

(d) Any methodology or other provision specified in Article 5.226 (commencing with Section 14168.1) or this article may be modified by the department, in consultation with the hospital community, to the extent necessary to meet the requirements of federal law or regulations to obtain federal approval or to enhance the probability that federal approval can be obtained, provided the modifications do not violate the spirit and intent of Article 5.226

(commencing with Section 14168.1) or this article and are not inconsistent with the conditions of implementation set forth in Section 14168.40.

(e) The department, in consultation with the hospital community, shall make adjustments, as necessary, to the amounts calculated pursuant to Section 14168.32 in order to ensure compliance with the federal requirements set forth in Section 433.68 of Title 42 of the Code of Federal Regulations or elsewhere in federal law.

(f) The department shall request approval from the federal Centers for Medicare and Medicaid Services for the implementation of this article. In making this request, the department shall seek specific approval from the federal Centers for Medicare and Medicaid Services to exempt providers identified in this article as exempt from the fees specified, including the submission, as may be necessary, of a request for waiver of the broad-based requirement, waiver of the uniform fee requirement, or both, pursuant to paragraphs (1) and (2) of subdivision (e) of Section 433.68 of Title 42 of the Code of Federal Regulations.

(g) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement this article or Article 5.226 (commencing with Section 14168.1) by means of provider bulletins, all plan letters, or other similar instruction, without taking regulatory action. The department shall also provide notification to the Joint Legislative Budget Committee and to the appropriate policy and fiscal committees of the Legislature within five working days when the above-described action is taken in order to inform the Legislature that the action is being implemented.

14168.34. (a) Notwithstanding any other provision of this article or Article 5.226 (commencing with Section 14168.1) requiring federal approvals, the department may impose and collect the quality assurance fee and may make payments under this article and Article 5.226 (commencing with Section 14168.1), including increased capitation payments, based upon receiving a letter from the federal Centers for Medicare and Medicaid Services or the United States Department of Health and Human Services that indicates likely federal approval, but only if and to the extent that the letter is sufficient as set forth in subdivision (b).

(b) In order for the letter to be sufficient under this section, the director shall find that the letter meets both of the following requirements:

(1) The letter is in writing and signed by an official of the federal Centers for Medicare and Medicaid Services or an official of the United States Department of Health and Human Services.

(2) The director, after consultation with the hospital community, has determined, in the exercise of his or her sole discretion, that the letter provides a sufficient level of assurance to justify advanced implementation of the fee and payment provisions.

(c) Nothing in this section shall be construed as modifying the requirement under Section 14168.13 that payments shall be made only to the extent a sufficient amount of funds collected as the quality assurance fee are available to cover the nonfederal share of those payments.

(d) Upon notice from the federal government that final federal approval for the fee model under this article or for any payment method under Article 5.226 (commencing with Section 14168.1) has been denied, any fees collected pursuant to this section shall be refunded and any payments made pursuant to this article or Article 5.226 (commencing with Section 14168.1) shall be recouped, including, but not limited to, supplemental payments, increased capitation payments, payments to hospitals by health care plans resulting from the increased capitation payments, increased payments to mental health plans, and payments for the health care coverage of children. To the extent fees were paid by a hospital that also received payments under this section, the payments may first be recouped from fees that would otherwise be refunded to the hospital prior to the use of any other recoupment method allowed under law.

(e) Any payment made pursuant to this section shall be a conditional payment until all final federal approvals necessary to fully implement this article and Article 5.226 (commencing with Section 14168.1) have been received.

(f) The director shall have broad authority under this section to collect the quality assurance fee for an interim period after receipt of the letter described in subdivision (a) pending receipt of all necessary federal approvals. This authority shall include discretion to determine both of the following:

(1) Whether the quality assurance fee should be collected on a full or pro rata basis during the interim period.

(2) The dates on which payments of the quality assurance fee are due.

(g) The department may draw against the Hospital Quality Assurance Revenue Fund for all administrative costs associated with implementation under this article or Article 5.226 (commencing with Section 14168.1).

(h) This section shall be implemented only to the extent federal financial participation is not jeopardized by implementation prior to the receipt of all necessary final federal approvals.

14168.35. (a) Notwithstanding any other provision of law, the director shall have discretion to modify any timeline or timelines in this article or Article 5.226 (commencing with Section 14168.1) if the letter that indicates likely federal approval, as described in Section 14168.34, is not secured by March 15, 2011, and the director determines that it is impossible from an operational perspective to implement a timeline or timelines without the modification.

(b) The department shall notify the fiscal and policy committees of the Legislature prior to implementing a modified timeline or timelines under subdivision (a).

(c) The department shall consult with representatives of the hospital community in developing a modified timeline or timelines pursuant to this section.

(d) The discretion to modify timelines under this section shall include, but not be limited to, discretion to accelerate payments to plans or hospitals.

14168.36. (a) Upon receipt of a letter that indicates likely federal approval that the director determines is sufficient for implementation under Section 14168.34, or upon the receipt of all final federal approvals necessary for the implementation of this article and Article 5.226 (commencing with Section 14168.1), the following shall occur:

(1) To the maximum extent possible, and consistent with the availability of funds in the Hospital Quality Assurance Revenue Fund, the department shall make all of the payments under Sections 14168.2, 14168.3, and 14168.5, including, but not limited to, supplemental payments and increased capitation payments, prior to July 1, 2011.

(2) The department shall make supplemental payments to hospitals under Article 5.226 (commencing with Section 14168.1) consistent with the timeframe described in Section 14168.11 or a modified timeline developed pursuant to Section 14168.35.

(b) Notwithstanding any other provision of this article or Article 5.226 (commencing with Section 14168.1), if the director determines, on or after June 15, 2011, that there are insufficient funds available in the Hospital Quality Assurance Revenue Fund to make all scheduled payments under Article 5.226 (commencing with Section 14168.1) before July 1, 2011, he or she shall consult with representatives of the hospital community to develop an acceptable plan for making additional payments to hospitals and managed health care plans in the third and fourth quarters of 2011 to maximize the use of delinquent fee payments or other deposits or interest projected to become available in the fund after June 15, 2011, but before September 15, 2011.

(c) Nothing in this section shall require the department to continue to make payments under Article 5.226 (commencing with Section 14168.1) if, after the consultation required under subdivision (b), the director determines in the exercise of his or her sole discretion that a workable plan for the continued payments cannot be developed.

(d) Subdivisions (b) and (c) shall be implemented only if and to the extent federal financial participation is available for continued supplemental payments and to providers and continued increased capitation payments to managed health care plans.

(e) If any payment or payments made pursuant to this section are found to be inconsistent with federal law, the department shall recoup the payments by means of withholding or any other available remedy.

(f) Nothing in this section shall be read as affecting the department's ongoing authority to continue, after June 30, 2011, to collect quality assurance fees imposed on or before June 30, 2011.

14168.37. Notwithstanding any other provision of law, if actual federal approval or a letter that indicates likely federal approval in accordance with Section 14168.34 has not been received on or before June 1, 2011, then this article shall become inoperative, and as of June 1, 2011, is repealed, unless a later enacted statute, that is enacted before June 1, 2011, deletes or extends that date.

14168.38. (a) This article shall be implemented only as long as all of the following conditions are met:

(1) Subject to Section 14168.33, the quality assurance fee is established in a manner that is fundamentally consistent with this article.

(2) The quality assurance fee, including any interest on the fee after collection by the department, is deposited in a segregated fund apart from the General Fund.

(3) The proceeds of the quality assurance fee, including any interest and related federal reimbursement, may only be used for the purposes set forth in this article.

(b) No hospital shall be required to pay the quality assurance fee to the department unless and until the state receives and maintains federal approval of the quality assurance fee as set forth in this article and Article 5.226 (commencing with Section 14168.1) from the federal Centers for Medicare and Medicaid Services.

(c) Hospitals shall be required to pay the quality assurance fee to the department as set forth in this article only as long as all of the following conditions are met:

(1) The federal Centers for Medicare and Medicaid Services allows the use of the quality assurance fee as set forth in this article.

(2) Article 5.226 (commencing with Section 14168.1) is enacted and remains in effect and hospitals are reimbursed the increased rates for services during the program period, as defined in Section 14168.1.

(3) The full amount of the quality assurance fee assessed and collected pursuant to this article remains available only for the purposes specified in this article.

(d) This article shall become inoperative if either of the following occurs:

(1) In the event, and on the effective date, of a final judicial determination made by any court of appellate jurisdiction or a final determination by the United States Department of Health and Human Services or the federal Centers for Medicare and Medicaid Services that any element of this article or any provision of Section 14166.115 cannot be implemented.

(2) In the event both of the following conditions exist:

(A) The federal Centers for Medicare and Medicaid Services denies approval for, or does not approve before January 1, 2012,

the implementation of Article 5.226 (commencing with Section 14168.1) or this article.

(B) Either or both articles cannot be modified by the department pursuant to subdivision (d) of Section 14168.33 in order to meet the requirements of federal law or to obtain federal approval.

(e) If this article becomes inoperative pursuant to paragraph (1) of subdivision (d) and the determination applies to any period or periods of time prior to the effective date of the determination, the department may recoup all payments made pursuant to Article 5.226 (commencing with Section 14168.1) during that period or those periods of time.

(f) (1) In the event that all necessary final federal approvals are not received as described and anticipated under this article or Article 5.226 (commencing with Section 14168.1), the director shall have the discretion and authority to develop procedures for recoupment from managed health care plans, and from hospitals under contract with managed health care plans, of any amounts received pursuant to this article or Article 5.226 (commencing with Section 14168.1).

(2) Any procedure instituted pursuant to this subdivision shall be developed in consultation with representatives from managed health care plans and representatives of the hospital community.

(3) Any procedure instituted pursuant to this subdivision shall be in addition to all other remedies made available under the law, pursuant to contracts between the department and the managed health care plans, or pursuant to contracts between the managed health care plans and the hospitals.

14168.39. Notwithstanding any other provision of this article or Article 5.226 (commencing with Section 14168.1), supplemental payments or other payments under Article 5.226 (commencing with Section 14168.1) shall only be required and payable in any quarter for which a fee payment obligation exists.

14168.40. (a) This article and Article 5.226 (commencing with Section 14168.1) shall become inoperative and the requirements for supplemental payments or other payments under Article 5.226 (commencing with Section 14168.1) shall be retroactively invalidated, on the first day of the first month of the calendar quarter following notification to the Joint Legislative Budget Committee by the Department of Finance, that any of the following have occurred:

(1) A final judicial determination by the California Supreme Court or any California Court of Appeal that the revenues collected pursuant to this article that are deposited in the Hospital Quality Assurance Revenue Fund are either of the following:

(A) "General Fund proceeds of taxes appropriated pursuant to Article XIII B of the California Constitution," as used in subdivision (b) of Section 8 of Article XVI of the California Constitution.

(B) "Allocated local proceeds of taxes," as used in subdivision (b) of Section 8 of Article XVI of the California Constitution.

(2) The department has sought but has not received federal financial participation for the supplemental payments and other costs required by this article for which federal financial participation has been sought.

(3) A lawsuit related to this article, Article 5.226 (commencing with Section 14168.1), or Section 14166.115 is filed against the state and a preliminary injunction or other order has been issued that results in a financial disadvantage to the state.

(4) The director, in consultation with the Department of Finance, determines that the implementation of this article or Article 5.226 (commencing with Section 14168.1) has resulted in a financial disadvantage to the state.

(b) For purposes of this section, "financial disadvantage to the state" means either:

(1) A loss of federal financial participation.

(2) A cost to the General Fund, that is equal to or greater than one-quarter of 1 percent of the General Fund expenditures authorized in the most recent annual Budget Act.

(c) (1) The director shall have the authority to recoup any payments made under Article 5.226 (commencing with Section 14168.1) if any of the following apply:

(A) Recoupment of payments made under Article 5.226 (commencing with Section 14168.1) is ordered by a court.

(B) Federal financial participation is not available for payments made under Article 5.226 (commencing with Section 14168.1) for which federal financial participation has been sought.

(C) Recoupment of payments made under Article 5.226 (commencing with Section 14168.1) is necessary to prevent a General Fund cost that is estimated to be equal to or greater than one-quarter of 1 percent of the General Fund expenditures

authorized in the most recent annual Budget Act and that results from implementation of a court order or the unavailability of federal financial participation.

(2) In the event payments are recouped for a particular quarter, fees paid by a hospital for that quarter pursuant to this article shall be refunded to the extent that the hospital meets both of the following conditions:

(A) The hospital has actually paid the fee for the subject quarter and for all prior quarters.

(B) The hospital has returned the payment received pursuant to Article 5.226 (commencing with Section 14168.1) for that quarter, or has had that payment recouped through a withholding of funds owed by Medi-Cal or other state payments, or recouped through other means.

(d) In the event the department determines that recoupment of supplemental payments is necessary to implement any provision of this section, the department may recoup payments made pursuant to Article 5.226 (commencing with Section 14168.1) from fees paid by the hospital pursuant to this article.

(e) Concurrent with invoking any provision of this section, the director shall notify the fiscal and appropriate policy committees of the Legislature of the intended action and the specific reason or reasons for the proposed action.

14168.40.5. Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department shall implement this article by means of policy letters or similar instructions, without taking further regulatory action.

14168.41. This article shall remain in effect only until January 1, 2013, the date of the last payment of quality assurance fee payments pursuant to this article, or the date of the last payment from the department pursuant to Article 5.226 (commencing with Section 14168.1), whichever is later, and as of that date is repealed, unless a later enacted statute, that is enacted before that date, deletes or extends that date.

SEC. 9. This act shall become operative only if Assembly Bill 113 of the 2011–12 Regular Session of the Legislature is enacted and becomes effective.

SEC. 10. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within

the meaning of Article IV of the Constitution and shall go into immediate effect. The facts constituting the necessity are:

In order to make the necessary statutory changes to increase Medi-Cal payments to hospitals and improve access at the earliest possible time, so as to allow this act to be operative as soon as approval from the federal Centers for Medicare and Medicaid Services is obtained by the State Department of Health Care Services, it is necessary that this act take effect immediately.

Approved _____, 2011

_____

Governor